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# Conservative Surgical Treatment of Para- and Peri-Uterine Septic Diseases.

BY

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# CONSERVATIVE SURGICAL TREATMENT OF PARA- AND PERI-UTERINE SEPTIC DISEASES.*

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The American Gynæcological Society is composed of experts who convene at regular intervals to discuss in a broad, dignified, and liberal spirit, various vital and important questions pertaining to the development of that branch of medicine in which they are especially interested. In most gynæcological societies the mere mention of the word "conservative" brings protests from all the ten-minute laparotomists—suggestions of radical work being just as certain to stimulate the most energetic expressions from general surgeons concerning the extreme views of the specialists. Without taking into consideration the dissenting views of the timid general practitioner of limited judgment, the exclamations of the two above-described gentlemen are becoming very fatiguing. The man of sense and conscience "who comes to town to stay" will be found all along the line as circumstances demand and as reason dictates. He who serves his patients best will reap gratitude at present and reverence in future.

Cœliotomy and removal of the uterine appendages as indiscriminately applied in the past is a most unsatisfactory operation. In spite of the great work and valuable lessons of the Taits and the Prices of both hemispheres, the short incision and the radical excision must fall back where they belong—to the selected cases where they fulfill the indications, and which we now know are not so numerous as formerly imagined, for we have come to realize that in many cases the operation was too much, and in many not enough. The woman of to-day insists not only upon having a radical operation done successfully, but she also expects to be cured of her disease, with its

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accompanying pains, aches, and discharges. The surgeon of exclusively great experience is positively not the best guide as regards operative indications. His dictum concerning technique and immediate results is invaluable ; whether he cures his patients of their diseases he seldom knows. The reason of this is evident. He does not practice medicine or surgery in the ordinary sense of the word. He reigns supreme over a college amphitheatre with its adjunct hospital, or he manages a large private sanitarium. Patients are sent to him by physicians who have learned of his great ability, and after a few weeks he sends them back cured of the operation, but frequently uncured of the disease. The doctor of one laparotomy always knows the result, both immediate and remote. A surgeon—of I should judge about three hundred laparotomies—in a discussion on this subject, mentioned that his results had been very satisfactory, that he did not have more than a dozen women who occasionally wrote to him concerning bad symptoms of pain or discharge. How deceptive ! Probably twice as many were writing or visiting some other surgeon, while a much greater number were at home nursing alike their sufferings and their loss of faith in the medical profession, and wishing their ovaries back.

This picture is a true one. A very reasonable proportion of my patients are complaining to me and a reasonable proportion of yours also, while you are listening to the same plaints, and quite an army are suffering in silence.

Salpingectomy, salpingo-oöphorectomy and oöphorectomy frequently fail to cure patients with peri- and para-uterine septic disease. Hysterectomy has of late years been found efficient in curing many cases that were still suffering after the first-mentioned operations had been performed. The impropriety of leaving behind frequently the chief offender among the pelvic organs has become evident, and a great step has therefore been made in the cure of these disorders. The amount of sentiment wasted upon the emasculated uterus, as Dr. Polk calls it, has always seemed ridiculous. Under such conditions, it is simply a cloaca for the origin of hæmorrhage, the accumulation of discharges, and the development of malignancy. Whether done abdominally or vaginally, this operation has a great future, and in spite of opposition has made wonderful strides because of the thoroughness of its curative effects. In this country it is only a few years since it has been performed with deliberate intent, and all its indications in view. It had originally been performed in an emergency, as a matter of expediency, when the destructive pro-

cess made it almost a necessity. Péan guided by his great surgical genius, first performed it, in his anxiety to cure a patient who had remained uncured after a salpingo-oöphorectomy. To-day it is an established procedure, and the position of advanced, observant gynæcologists, who are not hampered by tradition or custom, or afraid of their own stubborn, dogmatic expressions in the past, can be stated as follows: "In every operation for septic diseases of the female generative organs which demands the removal of the tubes and ovaries, hysterectomy should also be performed, unless there are plain contra-indications forbidding it." This means that this operation which ten or fifteen years ago was never done, which five years ago was rarely, and three years ago only exceptionally done, now, should be the rule. It does not mean more mortality, and it does mean more perfect and complete cure. After you have laid violent hands upon the ovaries, it matters not what becomes of the uterus. This tragic cry that an organ should never be removed without cause is all nonsense, in view of the fact that it has been proved innumerable times to be an element of mischief. This is true conservative surgical treatment in pelvic septic diseases.

But, gentlemen, before you touch the ovaries, then is the time for the display of your sentiment.

Whatever men may say, women do recover from salpingitis and pyosalpinx, from ovaritis, peri-ovaritis and ovarian abscess, from cellulitis and phlegmon of the broad ligament, whether these be of the catarrhal, puerperal, or gonorrhœal variety.

And they sometimes recover entirely and completely, so that this contingency, even if infrequent, must always be considered in forming surgical conclusions. Where surgical measures are considered proper and advisable, much depends upon the character and malignancy of the infectious material and the stage of the disease and amount of destructive process already present.

Having expressed the opinion that total ablation of the internal genitals of women in some cases presents the highest type of conservative work in the fact that it saves life and suffering, I beg leave to present for your judgment the result of some work I have done in the line of conservative surgical measures on the old lines of vaginal section. I will not weary you with extracts from the history of vaginal sections and punctures, written since time immemorial. What I have done is neither original nor a revival of the teachings of forgotten masters.

Pus sacs, or serous sacs, or exudated masses have been punctured

and incised in all manners and with all variation of instrumentation by surgeons for all times back. We have only to draw your attention to the writings of Laroyenne, Landau, Mundé, and innumerable others. Some have used the exploring needle and a trocar, emptied the cavity of its contents, frequently using irrigation. Others have introduced metrotomes through the trocar. Others, again, have incised directly and largely the septic focus or penetrated these pelvic cavities with different varieties of cautery knives. There is no need of mentioning authorities upon this subject, for the task would be interminable. It means simply that surgeons, recognizing the presence of inclosed septic material, have followed the general surgical rule of emptying, washing, and draining.

Sinclair, Mundé, and others advise free incision of tubes which are adherent to the peritonæum of Douglas' sac, *per vaginam*, subsequently washing out the empty tubes. Shröder has repeatedly employed this method in reaching adherent pyosalpinx. And so with many others, among whom I might mention particularly Reclus, Gusserow, Bouilly, Formento, of New Orleans, Cabot, of Boston, More-Madden, etc. Vuilliet (*Gazette médicale de Paris*, October 29, 1892) says that he has not done hysterectomy or abdominal section in suppurating pelvic disease in two years. In eighteen cases he has adopted Landau's method without accident, loss, or relapse, usually using a trocar, which, after carefully locating the sac, he plunges into the cavity. If no liquid appears he makes another puncture. He repeats this at the end of ten or twelve days; if the fluid reaccumulates he injects after the second puncture one to two and a half drachms of bichloride solution. If fluid returns after three or four punctures, he then incises and tampons with iodoform gauze, using a knife like a metrotome, slipping it upon the trocar. This is substantially the method described and practiced by Laroyenne and Landau, both of whom have written masterly treatises upon the subject. Laroyenne and Goullioud, his pupil, claim an important place in the treatment of pelvic inflammations for their method, which opens up largely by the vaginal route parametric chronic collections and holds them open until cicatrized. Their method applies to the diverse fluid collections in the pelvis, tubal dilatations, serous or purulent effusions in Douglas' sac, retrouterine hæmatoceles, parametric abscesses, etc. It suffices, they say, that the collection, large or small, should be clearly perceptible to bimanual palpation and be an inflammatory mass. It is not necessary to get fluctuation, which in the pelvis is difficult to make out. The immediate result is considerable ease, and eventually complete cure

even in multiple pus focuses. Distant results, they report, have been almost constantly satisfactory. Noticeable in this is the length of time in which note is made of the patient's condition. Laroyenne records in regard to ulterior condition all the cases which have been seen at least eighteen months after operation. Four women who had been operated upon afterward conceived and bore children.

Ablation of the annexæ remains as an ultimate resource in case pain continues; then it is simply salpingo-oöphorectomy without pus.

The greatest recommendation of the operations of these various men is its lack of danger. Goullioud gives a series of seventy cases, with one death occurring twenty-eight days after operating, due to an abdominal rupture of an unexplored pyosalpinx. He eventually reports another series of sixty cases, with one death, due to secondary operation for artificial anus, the patient having afterward been operated upon abdominally, and a fæcal fistula remaining.

Edmund Blanc, another pupil of Laroyenne, publishes a series of twenty-seven cases of chronic peri-uterine inflammation with serous, hæmorrhagic, or purulent effusions. Many others, however, speak of the danger of these incisions and punctures, particularly the danger of wounding the ureters or the uterine arteries. Hoffmeier speaks of these dangers, and says it is necessary to use sharp or puncturing instruments; also mentions the difficulties encountered when one can not exactly locate the pus sac.

There is no further need of multiplying these quotations, for not only does literature abound with them, but it is a subject with which you are all familiar, and the procedure is one which you all, at one time or another, have employed. Nevertheless, it seems desirable that in this age of wholesale ablations these simpler and often successful minor methods should not be lost sight of. Personally, I have frequently drained pus collections in the pelvis through the vagina, these pus collections being the result of chronic inflammatory conditions. It seems only reasonable to suppose that such operations may be successful, even in the most chronic forms of pyosalpinx. What happens in such cases? Septic material traveling up the Fallopian tube, when the process is not too rapid, finds itself arrested at the abdominal opening by a closure of the *ostium abdominalis.* An abscess cavity is developed in the walls of the tube proper. After a time the uterine end becomes closed, and then we have an independent pus sac, not communicating with either the serous or the uterine cavity. This may rupture into the folds of the broad ligament and work its

way toward the vagina. If widely opened and drained and packed, after a time all the so-called pyogenic lining membrane disappears, granulations fill the gap, the Fallopian tube becomes obsolete, and the patient is cured.

One of the reasons of failure of many men in the past is due to forgetting to pay the proper attention to the condition of the adjoining uterus, this organ being left unattended to and frequently giving rise to further trouble. I do not mean to propose, as some most enthusiastic followers of these various measures have done, the employment of this vaginal incision as a substitute for more radical and complete work, but I am simply endeavoring to impress you with the absolute necessity of discrimination, and, with that intent, I quote the success some that others have attained in curing even the most serious forms of trouble by conservative measures.

In treating chronic cases of inflammatory septic disease it is necessary to make sure that a patient is incurable by milder measures before resorting to the radical operations.

In the first part of this paper I have drawn your attention to the fact that many patients were cured of the operation while not cured of the disease, and that only the most complete ablations will suffice to cure some patients. But while we may, in the present state of our knowledge, be obliged to resort to the most serious radical operations to cure the patients entirely and properly, our minds should be constantly alert for the purpose of discovering methods by which the severer operations may be made available. The difficulty of understanding and analyzing pelvic inflammatory diseases becomes self-evident when we contemplate the many varieties of forms which the disease may take. A simple so-called catarrhal invasion of slow progress following the mucous channels may result in a chronic hyperplasia, sclerosed condition of the uterus, tubes, and ovaries, producing a most serious deterioration of health, and yet giving but very moderate evidence of its seriousness locally. Lymphangitis or phlebitis may bring about suppuration in almost any of the pelvic organs, or any part of these organs, giving rise to the most diverse and complex conditions. These inflammatory foci may cause fluid accumulations of a serous, hæmorrhagic, or purulent variety, or it may be only fibrinoplastic exudate, producing the most perplexing variety of symptoms and the most obscure localization.

The gynæcologist of the future who has a conscience must learn to carefully discriminate between cases. This whole subject will soon have to be gone over again by some master possessing practical experi-

ence and knowledge of the past, combined with an advanced special pathologic understanding. The day will come when it will not do to say "Take it out" or "Leave it alone" simply, but when, having found a proper curative method for each variety of case, or for each stage of the different varieties, the application of the remedy will correspond in the most exact manner to the particular conditions existing. Our concentrated attention should especially be turned toward the management of septic troubles in their incipiency. It is a part of the subject very improperly understood and presenting many difficulties. Patients, as a rule, depend for their care upon the general practitioner in the first stages of the disease. However competent and conscientious the gentleman may be, the multitudinous variety of his work makes it well-nigh impossible for him to devote special attention to this particular branch.

The time to cure septic inflammatory diseases—that is, to cure them completely and perfectly—is within the first few weeks of their appearance. We all know that a few days may bring about such a change in the pelvic structure of woman that a lifetime of careful, conscientious treatment, by the most competent of specialists, will not eradicate.

What means have we at our command this day to control or cure an invasion of septic material, either in the uterine cavity, or in the tube, or in the cellular tissue of the pelvis, or on the serous lining of the peritonæum? Mr. A., of New York, says dilate, curette, and pack at once, or the disease will be beyond your reach. Mr. B., of Philadelphia, says, Do not curette or do not pack, because you will bring about the most serious varieties of pelvic suppuration, for have I not noticed that all my abdominal sections have formerly been curetted? therefore curetting produces pyosalpinx, etc. Then Mr. C., of Baltimore, says, Curette and do not pack; and Mr. D., of Washington, says, Use hot douches, and never enter the uterine cavity, but keep the parts clean and at rest, and your patient will recover. What a chaos! The instrumentation of the uterine cavity, which in the hands of some apparently controls—cures the disease, becomes in the hands of others agents of destruction. An honest statement of facts must lead to the acknowledgment that many women suffer more from the doctor than the disease. Personally, I do not doubt that another decade will dispel many of the shadows hovering over the treatment of various stages of acute inflammatory affections of women. One of the most distressing experiences of the past has been the difficulty of preventing the disease from invading extra-uterine localities. A sep-

tic endometritis will affect the tubes, or the peritoneal cavity, or the parametric spaces, or the ovary, in spite of our most enlightened endeavors to control it. Once the disease has reached this point, with many men, no available means of treatment seems useful. Unfortunate women seem doomed to patiently wait for the surgeon's knife, dallying with the hot douche and the warm poultice, if the difficulty seems so acute that curettage is inadvisable or seems dangerous.

Allow me, with the object in view of endeavoring to fill this unfortunate gap in the treatment of inflammatory affections of women, to suggest for your consideration a method which has given me very satisfactory results in the treatment of acute inflammatory affections the last two or three years. Unfortunately, the number of cases is not sufficiently large to form a foundation for a very positive opinion, or the details explicit enough to lead to an analysis sufficient for differentiation. I can not state the procedure more definitely or plainly than by saying that for the last two or three years, whenever pelvic disease gave evidence of having penetrated beyond the cavity of the uterus, I have habitually made it a practice to make an incision behind the uterus, and digitally exploring the pelvis. However crude may be this explanation of the procedure, I am perfectly convinced of its great value. The vaginal incision, in the manner indicated, carries with it but little, if any danger. I have already pointed out to you how little risk there is encountered in puncturing or incising more or less chronic pelvic accumulations of a morbid kind by this route. In acute and early cases I have had occasion to operate within the last three years upon twenty-seven women, all of whom have made a satisfactory and, apparently, permanent recovery. This, however, represents such a small number, with so little experience, that deductions are only to be made with a great deal of circumspection. When an infection travels by way of the lymphatics into the broad ligament and produces what is known as a "phlegmon" of the broad ligament, its march is frequently excessively rapid, and a swelling occurs on one side or the other of the uterus, characteristic of these forms of disorders; or it may be that the infectious material travels by another lymphatic route, affecting the ovary only. Dr. William R. Pryor (*American Journal of Obstetrics*, July, 1893) thinks that there are two sets of uterine lymphatics—one surrounding the surface and extending laterally into the parametric spaces along the border of the broad ligament, the other following the course of the ovarian arteries, along the other margin of the broad ligament, and having their origin in a network surrounding the corpora lutea. Clinically, according to my experience,

this seems to be true, for repeatedly have I been able between the folds of the broad ligament to enter into and drain ovarian abscesses, other parts seeming apparently healthy.

The difficulty in presenting this matter to you properly seems to lie in the impossibility of differentiating the exact locality drained in each instance. Sometimes the finger penetrates posteriorly, apparently through the broad ligament, and separation of plastic exudate, lying between intestinal folds, is evident, showing the disease, in these instances, to have been a true peritonitis, the draining of which seems to be followed by amelioration. For many years I have followed but one rule in draining these cavities within the pelvis; this was, making an incision moderately circular, close to or rather slightly on the posterior surface of the cervix, and dissecting back the vaginal mucosa through the cellular tissue, to a point beyond which the wounding of the uterine artery seems improbable.

This incision never extends beyond the outer limits of the cervix. When, in dissecting back, through the connective tissue, closely hugging the posterior wall of the uterus, sufficient room is not gained, a perpendicular incision, beginning at the middle of the posterior border of the first, and running downward, parallel to the vagina, in the median rhaphe, is made, taking care not to penetrate sufficiently deep to wound the rectum beneath. With the exception of an occasional slight nick with the points of curved scissors, the finger is used exclusively in the manipulation. The disengaged hand being now placed upon the abdomen, the operator is to proceed the same way as in making bimanual palpation, and gradually penetrate the tissues in the direction of the center of the affected region. If the exudative mass is situated at one side or the other, the finger penetrates backward until the bimanual sensation indicates that the peritonæum, posteriorly, is almost reached. The finger now being turned to the right or left, as the case may be, and the superimposed hand being shifted to the affected side, there is usually no difficulty in penetrating the septic mass. As soon as the finger within reaches the exudative material, the sense to the touch will be self-evident. In the majority of cases an abscess cavity is found, a fact which is easily determined without withdrawing the finger. As, during these manipulations, the peritoneal cavity may have been accidentally opened, without our knowledge, it is better to retain the finger in the opening leading to abscess, and irrigation of the vagina may be practiced, with the finger still *in situ*, after which iodoform gauze is packed in the vagina, and in the wound proper up to the opening of the abscess; the finger now being with-

drawn, the pus is allowed to flow. Slight pressure may be practiced upon the abdominal wall, so as to empty the cavity as thoroughly as possible. The packing is now removed, the vagina once more cleansed, and the finger reintroduced into the abscess cavity a second time. Now comes an important part of the procedure, and that is the thorough exploration of the abscess sac, for the discovery of any additional collections in the neighborhood, each collection being treated in the same manner. The other side is now explored through the same vaginal opening, and, if necessary, the same procedures are here employed. Any hard, inflammatory masses are to be penetrated by the finger, whether they contain pus or otherwise. No instruments are to be used during any stage of the operation, after the vagina and submucous tissues have been incised. All inflammatory foci having been explored and penetrated, every portion of the cavity or cavities is to be carefully packed with iodoform gauze, wrung out in 1-to-3,000 bichloride solution. I have no doubt the packing with plain gauze and sterilized water may answer as well and possibly better. The ends of the gauze strips are to be carefully retained, so that they all protrude in the vagina through the vaginal wound. A little additional packing can frequently be advantageously placed in this vaginal buttonhole, so that it will remain quite distended, allowing a free drainage. The vagina is now moderately packed with gauze, and the operation is thereby made complete.

In some cases one will find the mass of exudate immediately posterior to the uterus in the median line. This inflammatory enlargement may be extra- or intraperitoneal. It matters not, it must be thoroughly penetrated and drained until it is evident by bimanual touch that the finger has reached its outermost limits. The finger is always, in all cases, to be worked from side to side until one's surgical sense indicates that drainage is more than sufficient. In other cases the finger will come almost at once upon the peritonæum, and the space at one's command, opposite Douglas' sac, may not exceed half an inch ; but if the finger now is turned to one side or the other, the layers of the broad ligament may be separated and the finger pushed in large masses at either side without opening into the general cavity; or, again, the finger being pushed to one side when the peritonæum is reached, the parts separated may be felt thin, pliable, and apparently perfectly healthy, until the operator reaches on the posterior wall of the broad ligament a round or oval, soft, thin wall, fluctuating sac, evidently an ovarian abscess. At this stage I have repeatedly had my assistant introduce the finger to palpate the sac wall before penetrat-

ing it, and giving an exit to a large amount of pus. In a reasonable number of cases no pus is found, the enlargements consisting entirely of a conglomerate mass of exudate. Particularly is this true of those forms of disease which are apparently intraperitoneal. Personally, I believe it makes but little difference in the result if the general cavity of the peritonæum is opened. A number of times, I am convinced that such was the case in my patients, but not the least reaction followed. In one instance, in a patient operated upon by a colleague, after this method, I pulled down a presenting portion of omentum to make certain of the fact, the patient recovering the same as the others. The packing is not removed for three, four, or five days, unless the patient's general condition indicates a retention of secretions. The wound may be kept open by a replacement of the packing three or four times, several days apart, but it has been my custom after eight or nine days, if the patient's condition is favorable, to simply use vaginal douches, taking care that the vagina is kept as aseptic as possible. No irrigation is to be used at the time of the operation beyond the vagina; but, if the abscess sac is large, it has been our custom to introduce a small tube and irrigate freely after the second or third dressing. The effect of this procedure in some patients is simply magical. The pains, hectic, and distress all disappear, and the patients, in the vast majority of instances, make a rapid recovery.

A uterus that has been retroverted and retroflexed is lifted, in the retro-uterine cases, to a higher plane, and remains after the cure in a much more preferable position. At the end of two to three weeks it often has almost entirely regained its mobility, and an examination of several of these patients a number of months later has seemed to me to leave very little to be desired.

In case the inflammatory affection has encroached upon the anterior vesico-uterine cellular pouch, bounded externally by the round ligaments, the same procedure can be used, making the incision in these instances anterior to the cervix and dissecting back between the uterus and bladder until the inflammatory center has been drained.

Allow me to give you a striking illustration of the value of this method. Four years ago a young girl, fourteen years of age, who had apparently had several attacks of appendicitis, developed a pelvic inflammatory affection which resulted in complete fixation of all the organs, the filling of the whole pelvis with large exudative masses, and resulting, after intense suffering and four months of critical illness, in an abscess, which, fortunately, made its escape by way of the rectum. After remaining well for a year and a half she suddenly developed

another acute attack of the same variety. I had failed to examine her in the interval between these attacks, so that I can not tell how far and completely she recovered, though she was apparently in perfect health. This, then, was a second attack, coming in a girl in apparent health, and ushered in by the most serious symptoms of rigors, fever, painful micturition, and painful defecation. Alarmed at the possibility of her having to go through the same ordeal as in the former instance, when her life was in such jeopardy, with the consent of her parents I immediately performed cœliotomy, intending, if possible, to abort the threatened destructive process, and, if necessary, remove the offending organs. The condition of the parts forbade further operative procedures by way of the abdomen. The uterus, ovaries, tubes, and all parts concerned, were absolutely fused into one conglomerate mass, which meant that, in a girl of sixteen, I would be obliged to do a complete ablation, with the greatest danger to her life, and the blighting of her future. Closing my abdominal incision, I put her upon her back, and through the little narrow vagina I incised the vaginal roof close to the cervix, anteriorly and posteriorly, penetrated both broad ligaments to their outermost limits, as well as the utero-vesical space, packing, as aforementioned, with gauze. No pus was encountered, but the disease was stayed. I examined this girl four weeks ago. She had been ill in bed only four weeks following the operation, and has now been fifteen months in perfect health. Her uterus is movable, though not to the same degree as you might expect in a perfectly healthy girl; but there is no thickening and no enlargement, and no appearance of disease.

For many years I have opened pelvic abscesses in this manner, never making use of any instruments beyond the first incision and a few nicks of the scissors in the second layer. Making the incision closely upon the cervix, adding to it the secondary incision at right angles down the vagina, if necessary, prevents hæmorrhage from the vaginal vessels. Once having reached the cellular spaces, the finger can be guided inward within the pelvis. It is, to me, infinitely safer, and to be preferred to various methods of trocar puncturing, needle exploration, and cautery knives. It is simplicity itself, and requires only a few minutes for its performance. But this matter of opening abscesses is an old, old story. It is the application of this method of treatment for the cure of inflammatory pelvic affections in their very incipiency.

Allow me to describe in a few short words my last case, as it represents a perfect type of the value of this method:

A young woman having forgotten herself, and being two days past her expected menstrual time, resorted to the services of an abortionist for the destruction of a supposed pregnancy, which, however, did not exist. Following the introduction of some instrument into the uterus, she suffered for two days very intense pain, accompanied by some fever. She was not, however, confined to her bed. The desired menstruation not making its appearance, at the end of six days she returned to the man's office, and a second instrumentation was followed in thirty-six hours by a severe chill, high fever, and excessive pelvic pain. On the sixth day of her illness I saw her in consultation, finding an inflammatory swelling to the left of the uterus in the broad ligaments. On the seventh day, under ether, I made the posterior vaginal buttonhole, penetrated the tissues with my left forefinger, and opened an ovarian abscess containing fully four ounces of pus. Eighteen days later this woman walked two blocks to the street cars and rode home. Her uterus was almost entirely movable; there was no apparent discharge; the woman was, to all appearances, cured.

Bear in mind the salient points of such history; refer back to cases of that variety which you have seen linger for months in bed, afterward returning for a laparotomy and an ablation of the appendages. Remember that this woman was sick only seven days, and yet a good four ounces of pus were found in her pelvis, and at the end of three weeks she returned home apparently cured—that is, physiologically, symptomatically, and, to all appearances, entirely cured.

It is not only the application of the old surgical principle to evacuate pus as early as recognized, but this operation strives to go further. It shows to us that, pus or no pus, the character of exudative material of the variety that is usually found in the pelvis is susceptible of absorption when broken up and drained. In some way, as happens within the peritoneal cavity when a drain is introduced, septic material from within seems to be drawn toward the breach that has been made, and if sufficient outlet has been provided, and if the parts are kept sufficiently aseptic to prevent mixed forms of infection at that site, the bacteria are usually destroyed and expelled, the exudative material is replaced by granulating tissue, and a cure results. No matter what success a man may have as a skillful enucleator of large and old pus sacs, he must indeed be bold who would deny the advantages of an early incision through the vagina if it can be followed by such good results as are apparently shown by cases as they have come to my notice. The objections that hold good against the vaginal incision in old pyosalpinx and other cavities which have destroyed, to a great

extent, the organs in which they originate, have but little weight when applied to the procedure which I advocate. We are here simply incising, irrigating, draining localities permeated with recent lymph. The more I see of this work the more I have reason to believe that it is of value, and probably it will soon be determined that the earlier the operation is done the more striking its benefits. It is a question with me whether it will not be recognized in the future that an incision in the Douglas sac, performed at the very incipiency of a pelvic peritonitis, establishing a drainage for the primary serous effusion that occurs, will not prove an invaluable means of aborting and controlling these nefarious processes. It means the elimination of the noxious material as soon as it becomes palpable.

I had almost forgotten to say that in every single instance when this operation is performed the uterus is to be carefully, thoroughly, and intelligently curetted. Failure to cure incipient septic disease of women arises most frequently from an inability to exactly locate and reach the exact seat of the affection. If a woman suffers from an endometritis, pure and simple, she can be cured by an intelligent and thorough curetting, if every vestige of the diseased tissue can be reached and removed. Here we have facing us the frequent inability to reach the cornua of the uterus, at the opening of the Fallopian tubes. In some cases, without our knowledge, the disease has already encroached upon the tubes themselves, and, to a certain extent, beyond our reach. In other varieties, some of which also we are not able to diagnosticate, the virulent micro-organisms have penetrated through some of the aforementioned channels, beyond the uterine body, in one or the other direction, and my contribution to your understanding of this subject is an attempt to point out another method of combating these unfortunate affections, according to reasonable indications. The demonstration of the value of my suggestions will probably fall within the province of the consulting man, whose practice brings him face to face with these diseases in the first part of their course. The great hospital operator will probably see but few of these cases at a sufficiently early stage to verify the value of the proceeding. It has seemed to me to be a most valuable adjunct in the treatment of the septic diseases of women, and is presented to you with the hope that it may become a respectable addition to the methods in vogue for the conservative surgical treatment o these affections.

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